EXHIBIT 2

HIPAA COMPLIANT AUTHORIZATION
FOR RELEASE OF INFORMATION

Patient Information:

Child Name: _____

DOB: _____ SS#: _____

_____
Address, City, State, Zip Code

Information to be released from:

Name of designated Facility or Provider

_____

_____
Facility or Provider Address
City, State, Zip Code

Information to be released to:

Information to be released:

- ☒ All medical & billing records.
- ☐ Other (please specify): _____

Purpose of disclosure: Investigation of Lead Poisoning Claim

_____ I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug abuse, psychiatric, HIV/AIDS, sexually transmitted disease, or genetic information.
(**Initials**)

My Rights:

This authorization is pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 *C.F.R.* Section 164.500 through 534. The person signing this authorization has a right to receive a copy hereof, and a reproduced copy of this authorization shall be as valid as the original. This authorization is in force from the date of signature herein due to the nature, duration, and extent of this case. This authorization applies to all records both prior to, and after the date of signature. I understand this consent may be revoked in writing at any time. With the exception to the extent that disclosure of information has already occurred prior to the receipt of revocation by the above-named provider. If written revocation is not received, authorization will be considered valid for a period of time not to exceed 365 days from the date of signing. To initiate revocation of this
authorization direct all correspondence to the "Designated Recipient" above. I understand that I need not sign this authorization in order to ensure healthcare treatment, payment or enrollment in my health plan or eligibility of

benefits.

Further, I am informed and understand that information disclosed pursuant to this authorization could be re disclosed by the recipient to others. In some cases, such re-disclosure may no longer be protected by federal confidentiality laws (HIPAA).

SIGNATURE: _____ **DATE:** _____